EVIDENCE OF INSURABILITY (EOI) Instructions

Washington State Health Care Authority

When you need more Life Insurance.

By completing the Evidence of Insurability (EOI) form, you are providing the additional information needed to review your request. Any Guaranteed Issue amount available to you will be provided regardless of your EOI application.

1. Getting Started:

- State of Washington personnel, payroll or benefits office should complete the following prior to providing the EOI form to the employee:
  - Complete Section **A**.
  - Complete Section **C**, Column **B**.
  - Sign and Date Confirmation at bottom of Section **C**.
- Employee:
  - Know how much insurance you need.
  - Know your/your spouse/state-registered domestic partner's primary health practitioner contact info.

2. Completing the EOI:

- If you do not require underwriting for your spouse/state-registered domestic partner, you do not need to complete those sections.
- Complete all other sections of this form.
- The privacy and security of your personal contact and health information is critically important to us.
- We will not share your information with your employer or anyone not directly involved in the underwriting process per the attached privacy statement.
- Personally sign and date this form as employee. (Your spouse/state-registered domestic partner's signature is only required if you are applying for spouse/state-registered domestic partner's coverage.)

3. Submitting Your EOI Application:

- Make a copy of Your EOI form for your records.
- Submit your EOI form to ReliaStar Life Insurance Company. Mail and fax information is included on page 3 of the EOI form.
  - **Fax to:** 1-612-342-3913
  - **Mail to:**
    ReliaStar Life Insurance Company
    PO Box 20, Route 7812
    Minneapolis, MN 55440

4. Questions:

- Your plan is administered by your employer. Any questions regarding plan provisions, coverage amounts and/or payroll deductions should be directed to your personnel, payroll or benefits office. If you have general questions regarding form completion, call **1-866-689-6990**.
- Call Reliastar Medical Underwriting Customer Service at **1-800-537-5024**, Option **4**, only if you have a question on the status of your submitted EOI.
- Medical Underwriting does not have information concerning the amounts you should indicate on your EOI form.

FORM EXAMPLE AND DEFINITIONS

Coverage Type Use the check boxes to choose the types of coverage(s).

(A) This is the total amount of life coverage desired.

(B) Have your personnel, payroll or benefits office complete this section prior to you completing the health questions.
This is the current amount of insurance being deducted from your pay.

(C) This is the amount your plan allows you to have, when you are newly eligible, without completing the health questions on this form.

If you are enrolling after your initial eligibility and no longer qualify for the Guaranteed Issue coverage, just enter $0 here.

Coverage Type	(A) Total Amount Desired	(B) Current Amount	(C) Guaranteed Issue Amount	(A) – (B) – (C) = Amount to Be Underwritten
☑ **Employee Supplemental Life**	**$350,000**	**$50,000**	**$0**	**$300,000**
☑ **Spouse/Domestic Partner Basic Life**	**$2,500**	**$0**	**$0**	**$2,500**
☑ **Spouse/Domestic Partner Supplemental Life**	**$50,000**	**$0**	**$0**	**$50,000**

Employee Benefits

EVIDENCE OF INSURABILITY (WA)

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the ING family of companies
PO Box 20, Route 7812, Minneapolis, MN 55440
Phone: 1.866.689.6990 Fax: 612.342.3913

ING
Your future. Made easier.®

Use this form to apply for insurance coverage in addition to coverage you may already have through this plan.

A. AGENCY/POLICYHOLDER INFORMATION *(Personnel, payroll, or benefits office completes this section.)*

Group Number **123731** Account Number _____ Employer Name **Washington State Health Care Authority**

Agency/Subagency Code _____ Employee Hire Date _____

B. EMPLOYEE INFORMATION

Employee Name *(First, MI, Last)* _____ Gender: ☐ Male ☐ Female

SSN _____ Birth Date _____

Address _____ City _____ State _____ ZIP _____

Home Phone (_____)_____ Cell Phone (_____)_____

Primary Health Practitioner _____ Practitioner Phone (_____)_____

Practitioner Address _____ City _____ State _____ ZIP _____

C. INSURANCE DETAILS *(Complete this table based only on the coverage you have through this plan)*

Are you completing this form due to a Family Status Change *(Marriage, Divorce, Birth, Adoption, etc.)*? ☐ Yes ☐ No

Coverage Type	(A) Total Amount Desired	(B) Current Amount	(C) Guaranteed Issue Amount	(A) – (B) – (C) = Amount To Be Underwritten
		(Agency to Complete)		
☐ Employee Supplemental Life	$	$	$	$
☐ Spouse/State-Registered Domestic Partner Basic Life	$	$	$	$
☐ Spouse/State-Registered Domestic Partner Supplemental Life	$	$	$	$

After signing you may select eMail or Print. > Email Print

Agency confirmation completed by *(Agency /Policyholder Contact)* _____ Today's Date _____

D. SPOUSE/STATE-REGISTERED DOMESTIC PARTNER INFORMATION

Spouse/State-Registered Domestic Partner Name *(First, MI, Last)* _____ Gender: ☐ Male ☐ Female

SSN _____ Birth Date _____

Home Phone (_____)_____ Cell Phone (_____)_____

☐ Same Primary Health Practitioner as Employee *(See information above.)*

Primary Health Practitioner _____ Practitioner Phone (_____)_____

Practitioner Address _____ City _____ State _____ ZIP _____

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Employee Name _____ SSN ***(Last 4 digits only)*** _____

E. EMPLOYEE AND SPOUSE/STATE-REGISTERED DOMESTIC PARTNER HEALTH QUESTIONS *(Must be answered for coverage that is not Guaranteed Issue.)*

Employee (EE) Yes	Employee (EE) No	Spouse/ Domestic Partner (SP/DP) Yes	Spouse/ Domestic Partner (SP/DP) No	
☐	☐	☐	☐	1. Have you ever been treated for or been diagnosed by a member of the medical profession or health practitioner as having a positive HIV test or AIDS (Acquired Immunodeficiency Syndrome)?
☐	☐	☐	☐	2. Have you ever had, or been treated for, any of the following: insulin dependent diabetes, heart attack, coronary bypass/ angioplasty, heart valve repair/replacement, stroke, metastatic cancer, emphysema or been an organ transplant recipient?
Complete for EE and SP/DP. --->				3. **Employee:** Height _____ ft. _____ in. Weight _____ lbs. **Spouse/DP:** Height ___ ft. _____ in. Weight _____ lbs.
				4. In the past 10 years have you consulted with, been diagnosed or treated by a health practitioner, or taken medication for any of the following:
☐	☐	☐	☐	a. Disease or disorder of the heart, blood vessels (excluding controlled high blood pressure), lung (excluding asthma), liver (excluding hepatitis A), pancreas, or intestine?
☐	☐	☐	☐	b. Non-insulin dependent diabetes, impaired glucose tolerance, or pre-diabetes?
☐	☐	☐	☐	c. Cancer or tumor, rheumatoid arthritis, connective tissue, neurological (excluding headaches), autoimmune or blood disorder?
☐	☐	☐	☐	d. Depression, psychosis, suicide attempt, drug or alcohol abuse or addiction?
☐	☐	☐	☐	e. Polycystic kidney disease or kidney failure?
				5. Have you ever been diagnosed, treated or given medical advice by a physician or other health practitioner for:
☐	☐	☐	☐	a. Chest pain, heart trouble or circulatory disorder?
☐	☐	☐	☐	b. Anemia or leukemia?
☐	☐	☐	☐	c. Sleep apnea, asthma or other respiratory disorder?
☐	☐	☐	☐	d. Colitis, Crohn's disease, ulcerative colitis or any other intestinal disorder or disease?
☐	☐	☐	☐	e. Stomach disorder?
☐	☐	☐	☐	f. Brain or seizure disorder?
☐	☐	☐	☐	g. Mental or nervous disorder?
☐	☐	☐	☐	h. Arthritis, paralysis or any muscle weakness?
☐	☐	☐	☐	i. Abnormal urine specimen or urinary tract disorder?
☐	☐	☐	☐	j. Prostate or other reproductive organ disorder?
☐	☐	☐	☐	6. Are you pregnant? Due date _____ Pre-pregnancy weight _____ lbs.
☐	☐	☐	☐	7. Do you currently have any disorder, condition, disease, and/or are you currently taking medication prescribed or provided by a physician or other health practitioner for any disorder, condition, disease not shown above?
☐	☐	☐	☐	8. Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a health practitioner to discontinue the use of such substances?
☐	☐	☐	☐	9. In the past 2 years have you experienced any symptom(s) for which you have not yet consulted a health practitioner, or are any medical, surgical or diagnostic procedures recommended or contemplated?

For every "Yes" answer to any question in the previous section, give details below. Please attach a separate sheet if additional space is needed.

Question Number	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Fully Recovered?	Health Practitioner Name, Full Address (Street, City, State, ZIP), Phone
	☐ EE ☐ SP/DP				☐ Yes ☐ No	
	☐ EE ☐ SP/DP				☐ Yes ☐ No	
	☐ EE ☐ SP/DP				☐ Yes ☐ No	
	☐ EE ☐ SP/DP				☐ Yes ☐ No	

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Employee Name _____ SSN ***(Last 4 digits only)*** _____

F. AUTHORIZATION AND ACKNOWLEDGMENT *(Please read and sign below.)*

For underwriting and claim purposes, I give my permission to any physician or other medical practitioner, hospital, clinic, insurance or reinsuring company, MIB, Inc. (MIB), any consumer reporting agency, or any other organization to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below). This includes but may not be limited to: (a) findings on medical care, psychiatric or psychological care or examination, or surgery, as they apply to me; and (b) any non-medical information as it applies to me. I give my permission to ReliaStar Life to obtain consumer or investigative consumer reports about me.

I give my permission to ReliaStar Life and other insurance companies affiliated with ReliaStar Life to obtain any and all medical record information for the purposes described in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations–42 CFR Part 2. I may revoke this permission as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it. I specifically consent to the re-disclosure of medical record information as set forth in this form. In connection with any application for life insurance, or other insurance transaction that I may have with ReliaStar Life or any of its affiliated companies, I understand that I may request that this information not be communicated to companies affiliated with ReliaStar Life.

I authorize ReliaStar Life, or its reinsurers, to disclose personal health information about me to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and detection programs.

I understand that my further written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not before specified. My further consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have a right to receive a copy of this form. I certify that I have, will print, or will otherwise have access to a copy of all pages of this Evidence Form to keep for my records. A photocopy of this form will be as valid as the original. This form will be valid for 24 months from the latest date shown below.

I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice and Insurance Information Practices Notice.

IMPORTANT! Please carefully read the next section. Then sign and date below.

I declare that all of the statements and answers, as they pertain to me on all pages of this Evidence Form, are complete and true to the best of my knowledge and belief.

I realize that any misrepresentation or omission regarding the presence of any pre-existing impairments and/or diseases may result in the requested coverage or benefits provided by such coverage being contested. I understand that any claim incurred prior to the approval of this Evidence Form by ReliaStar Life Insurance Company's Home Office will not be valid.

I understand and agree that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Employee Signature _____ Date _____

Spouse/State-Registered Domestic Partner Signature _____ Date _____

Submit your EOI form directly to the insurer for fast and confidential handling via one of the methods below:

Fax to: 1-612-342-3913

Or

Mail to: ReliaStar Life Insurance Company, PO Box 20, Route 7812, Minneapolis, MN 55440

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CONSUMER PRIVACY NOTICE AND INSURANCE INFORMATION PRACTICES NOTICE

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the ING family of companies

ING
Your future. Made easier.®

We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures

For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices

Collecting Information

Your application or claim form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from MIB, Inc., formerly known as the Medical Information Bureau. See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with us. The information may be kept by the consumer reporting agency; it may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc.

We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB's phone number is 866-692-6901 (TTY 866-346-3642). We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.